Department of Health and Human Services
Division of Health Care Financing and Policy
Medical Care Advisory Committee (MCAC)
Minutes of Public Meeting
January 18, 2007

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Agenda I
The meeting was called to order at 9:04 a.m. by the Chairman, Rota Rosaschi originating from Carson City and aired by video conference to Las Vegas. Committee members were present as follows: Keith Macdonald, Conrad Blake, Fredrick (Freddy) Rundlet, Conrad Blake, Keith Macdonald. There were no MCAC members in Las Vegas. A quorum was present.

Agenda III
Chairman Rosaschi asked the Committee to review the MCAC minutes from the February 17, 2005, June 08, 2006, and August 24, 2006 meetings. The February 17, 2005 minutes were approved with no opposition. The June 08, 2006 minutes were approved with minor typographical changes. The August 24, 2006 minutes were approved with a motion by Dr. Fiore to keep future minutes more condensed.

Agenda IV
Charles Duarte discussed his expectations of the Committee per NRS 422.151, his hopes are to be able to bring matters to the Committee for consideration, review and seek advice on matters that are substantive in nature and may lead to changes in the program, including budget issues and balancing funds. There will be some program initiatives the agency will be undertaking and the Division will seek advice from the Committee on how to structure the programs in a manner that achieves goals to improve the quality of life and care received by recipients while at the same time making sure the agency's tax dollars are spent wisely while staying under the statutory expenditure cap.

Mr. Rundlet asked where this Committee stands with regards to statistics showing Nevada having one of the highest health cares costs in the country, what is the Committee's role in responding to these statistics and working with various agencies of State government and trying to improve these statistics.

Mr. Duarte agreed with Mr. Rundlet's comments and stated that per capita funding of Medicaid, Nevada is always last, and this impacts the federal funding we get. This funding needs to change at the level of the Legislature. Recommendations are made to the Governor and the Legislature for improvements in the program, enhancements, services and spending, and it's up to them to accept the recommendations.

Mr. Rundlet asked Mr. Duarte if the State of Nevada submitted an application for grant money that was available for adoption of innovative methods to improved Medicaid programs in the United States. Mr. Duarte responded that grant applications for several different initiatives were submitted funded through the Deficit Reduction Act.

Chairman Rosaschi asked if the MCAC Committee would like to put together a "visioning" meeting. Mr. Duarte stated he would host one as an agenda item, and they could discuss some of the initiatives that are included in the budget and outside the budget at that time.

Dr. Fiore asked what the Committee's role is regarding advocacy and State regulations, can they meet with Legislators and advocate for an increase in the budget and if so, then they should meet before session and not a regularly planned meeting.

Mr. Duarte stated that February would be a good time for meeting as that is when Legislature gets busy.

Mr. Faircloth stated that the mandate of the Committee is to seek to improve quality of health care the Medicaid program can deliver to recipients, and as such, Mr. Duarte's role is to administer funds that Legislature deems fit to provide, thus it may be appropriate for the Committee to make recommendations both to Medicaid and to the Legislators and/or the Governor for improvements in the program.

Agenda V

Mary Wherry, Deputy Administrator discussed utilizing a Managed Care Organization (MCO) for the aging, blind and disabled population (ABD). Within the Medicaid population, although the AGB population is only 20%, they account for 56% of Medicaid spending. This is common with most other states as well.

Providing managed care for the AGB population would allow better access to care for recipients, as the plan is responsible for assuring an adequate provider network. In bringing up a managed care plan, DHCFP would assess with each plan how many primary care physicians (PCP) and specialists they have that are unique to that population and how many ancillary services are available to make sure the totality of need for the recipients would be met. The managed care plan would be accountable to provide oversight to providers for the quality of care being provided-something very difficult in a fee-for-service (FFS) population.

Because a managed care program's motivation is to increase their profit margin by making sure their recipients are accessing the most cost-effective care, we can be assured a managed care program will have enhanced services. The managed care plan can manage the population and make sure the recipients are following through on appointments, coordinating with providers, as well as track the recipients on a regular basis to make sure they are compliant with their health care recommendations.

A managed care program assists recipients with making appointments and also does reminders and follow-up on needed treatment. Managed care also assists in developing and carrying out a plan of care for the recipient, working closely with the PCP and any specialists involved.

A managed care program help in managing pharmacy issues is another benefit expectation. It would not just be a cost savings, but an improvement in the quality of life for recipients, especially with dual eligible recipients that also have Medicare Part D.

DHCFP has been collecting data on how difficult it is for recipients that go into nursing homes and facilities to try and move back into the community. Sometimes the recipients "give up" and resign themselves to thinking they must remain in a nursing home/facility for the rest of their lives. It would be less confusing for recipients if they had a medical home managed by the managed care plan, where they can call for assistance with help navigating the health care system.

Ms. Wherry continued... (unintelligible) the plans accountable for the development and collection of measurable health outcome data, to demonstrate the true benefit of the MCO. Looking at a slide presentation titled "Managed Care for the ABD Population, the 8th slide has to do with containing costs. How do we take the limited dollars appropriated to us by Legislature and make the best use of them to improve the quality of our recipient's care.

The first one is managing the policy pharmacy component, as spoken about earlier. The next one is that the managed care plans have the ability, because they typically have a greater share of the market than just the Medicaid population, they're able to negotiate rates with providers that may be different than the rates that we pay from a fee-for-service perspective. Sometimes our managed care plans pass through the fee-for-service rate and make their profit on truly managing the care so that it's the best quality outcome with the least amount of cost. There would be fewer unnecessary visits, it's believed, and we have a lot of recipients who rely heavily on emergency rooms. That is the most expensive area a recipient could go for fundamental medical care, when if they had a managed care home and they

utilized that home, we would be saving money right away. We also believe this would result in shorter lengths of stays in hospitals. We do have a utilization management company who assures that our length of stays for nursing facilities for any type of institutional care and outpatient professional care is within DHCFP's criteria for utilization management and utilization control under the fee-for-service program; however, they're not responsible for making the coordination necessary to move someone from the hospital back into the community. They are there simply to make the decision as to whether or not it's medically appropriate for that person to continue to stay in the institution. There are a number of recipients who go to what is referred to an "admin" level of care, where we only pay an administrative cost, because they no longer meet the medical acuity to stay in the institution, but there's no discharge plan to move them back into the community, or they haven't found a nursing facility that can accept that placement as of yet. If they end up going to the nursing facility because no one is monitoring their care and coordinating it for them, then we'll be paying the high dollar for unnecessary nursing facility utilization.

That is the difference between what a managed care plan would do and what we currently do in fee-for-service with First Health. They would be very much focused initially on targeting what we call the "low-hanging fruit"; going after the population that is the highest cost This may be from a disease perspective or recipients who are frequent-flyers of emergency rooms, inpatient hospitalization-short length of stays, but excessive. To first target this population, this is the easiest way to get control of a population and reduce the expenditures, and also to start measuring some of the outcomes.

One of the greatest benefits for DHCFP is that this is a risk-based contract. There are other alternatives for managing the care of this population, but those alternatives don't involve the managed care plans taking the risk. We pay a per-member, per-month rate to the managed care plans for each recipient who is enrolled in that plan for that month. We also have a stop-loss agreement, which means if a managed care plan starts to experience a very expensive recipient, they only have to bear the risk up to a certain dollar amount; then we begin to share in the risk beyond that. If we set that dollar amount high enough for the stop-loss, then the managed care plans are incentivized to try and manage everyone below that because the more expensive their clients become, the less their profit margin is. They take full responsibility for the medical expenditures, and that is their risk, until they reach that stop-loss payment. Currently for our TANF and CHAP population that is at $100,000.00 and we would have to look at what that stop-loss might be for the MAABD population because it's a much more costly; more inclined to consume a lot of health care costs.

Slide 9, one of the challenges for the legislature in terms of whether or not this will be a proposal they're interested in. The fiscal challenge for us for the first year or two of trying to implement a managed care plan is that we have a stale date claiming period in Nevada Medicaid of 180 days. But as we all know there are many reasons a claim may not pay within that 180 days. It may have taken longer for the provider to get Third Party Liability payment from another insurer; there may have been problems with a claim and it had to be resubmitted numerous times before being paid, etc., It can extend out over a several year period that we are still incurring the claims cost of a recipient who was in fee-for-service and now is in managed care. When a managed care plan starts, that first month we begin paying that per-member, per-month. But at the same time, we're still paying historical claims that have been incurred, but not paid yet for those same recipients. In some ways we're duplicating our expenditures from our budget until we get caught up and pay all the historical claims. This is what we call the "Claims Tail" and that's the piece that we don't show an immediate savings from managed care that is of great significance to the State until we've resolved that debt.

One of the great benefits for Nevada Medicaid for managed care is it helps us get control over our budget forecasting. We can't tell you from one year to the next what the true expenditures are going to be for the ABD population. If you look at the slides for 2006 costs, it's said we were at 56-60%. Typically we're around 70 – 76% of our total budget is expended on the ABD population. We have no idea what the costs are going to be, cannot discern how many trips a recipient will make to the emergency room, etc., we can only go with the trend data we have. With a managed care plan, we are

able to, with the Actuary, have a greater confidence level about what our per-member per-month costs will be; and to extrapolate that over our budget period, and have a greater degree of control over what our costs are going to be. That gives us much more credibility when we go before the Legislature, trying to make budget projections.

Mr. Rundlet asked Ms. Wherry if the numbers of people that Ms. Wherry categorizes as blind and disabled, does she know approximately what percentage of those cases are congenital cases vs. something that was acquired in their life time.

Ms. Wherry stated we don't maintain that type of data.

Mr. Rundlet continued...For those that were acquired in their lifetime, for example, by an auto accident, a worker's compensation injury, etc., does the state recover payments from those insurance sources first before any payments are made? Is there a system in place for that?

Ms. Wherry responded that it may not necessarily be first, if someone becomes eligible for Medicaid, they're eligible for all benefits. Nevada Medicaid may pay a claim before it's realized that the recipient has a subrogation opportunity, but Nevada Medicaid would go after that subrogation, whether it's up front or through the process of their health care delivery. Nevada Medicaid would be working with that other party to ensure we got the subrogation payments.

Mr. Rundlet asked if that recovery is realized, where does that money go.

Ms. Wherry answered that it goes back to the Medicaid budget.

Mr. Rundlet asked if the numbers of ABD are increasing; and is the rate of increase a fast rate that is of concern?

Ms. Wherry stated yes, but it's a fairly stable rate of increase, but consistently going up. As more seniors come into the state, the potential for it to grow at a faster rate is real. The TANF and CHAP population is much more sensitive to what happens in the overall economy of the state and the nation. For example, after 9/11 when all the state's budgets took a nose dive, and all states were having to tighten their budgets and figure out how they were going to cover an expanded population-because of rising unemployment rates, people not flying in and accessing the gaming industry to contribute to our economy etc., our TANF and CHAP populations grew significantly. But they stabilized and now have actually decreased some. This does not happen in the ABD population.

Ms. Wherry asked why we're looking at this as an alternative. Looking at Slide 11, this is today's reality. Nevada Medicaid recipients don't have an option to access their benefits through a managed care population and they are the most vulnerable of our population. There is no coordination of their needs; and most are very confused and afraid. For example, with the personal care program, there are many stories told by friends of recipients, and those recipients not afraid to be vocal. Some of these recipients are at the mercy of their direct care provider; their personal care aid may be coming into the home just to say they were there, and not necessarily to provide the service they are there to provide. They may physically or verbally abuse a recipient; they may steal from them or just not provide good quality care. Nevada Medicaid does what it can with the limited staff that we have to ensure some quality in that regard from a fraud and abuse perspective. If the recipient develops a relationship with a care coordinator over time, however, that is one more mechanism to make sure their needs are being met. Other than the District Office staff, elder abuse or social service agencies, that is not available. Many recipients are told by their direct care providers that if they tell someone about poor or lack of services, they'll lose the services all together. The recipients don't know any better and don't say anything. There are reasons for our wanting to give our recipients someone to help navigate the health care system.

There is no coordination currently between physicians and others providing treatment and that's a problem for the provider as well. For example, there are limitations on therapy services. We have recipients who may be getting physical therapy, occupational, and speech therapy. These recipients may be getting them from multiple providers of the same profession. There may be more than one physical therapist seeing a client. The client doesn't track themselves; they just show up for the appointments and make sure their needs are being met. The providers have a big risk. They may think they have received a prior authorization for a certain number of visits, but they don't know there is another prior authorization out there for a different provider for the same services. Between the two providers they are going to hit a limit faster than either of them realizes. If Medicaid only allows 12 therapy visits per year, for example, and both providers have authorization for 10 visits, one of them is going to hit that 13th visit and when they submit their claim, it will be denied. This goes to show that it is also costly for the providers when no one is overseeing the coordination of care for the recipient.

There are recipients that use multiple pharmacies as well. We have the ability within the Medicaid program to do a "lock in", where we can lock in a recipient into a specific physician and/or pharmacy. Nevada Medicaid has not yet exercised this option through the drug utilization review process, but it's something that managed care plans would be more readily able to do. They have a smaller population they are heavily targeting and looking at the utilization. They also have the staff to do that.

We have recipients that can go to five physicians, and get five prescriptions for narcotics and go to five different pharmacies to get those prescriptions filled. Then they can turn around and sell those prescriptions that Medicaid has purchased. Therefore, due to the lack of communication, there is an increase in cost in utilization.

Ms. Wherry already spoke to the existing lengthy hospital and nursing facility stays. The bed days per thousand used to be one of the highest in the nation. We haven't significantly improved in our hospital utilization from where we were 8 years ago. It's a budgeting nightmare trying to anticipate what our costs are going to be for this population, and we believe there is a significant amount of money being wasted due to lack of coordination.

Managed care plans want the healthiest population because that will help their profit margin. Many believe that managed care means second class care. We don't believe that to be true, in fact, a few months ago there was a child recipient who had been fee-for-service but had such significant health care needs a provider could not be found for him. After placing the child in managed care, he was able to access all the care he needed because the managed care plan had a greater panel of providers and the ability to navigate the system.

Many people presume managed care is unaffordable. Historically State employees have had the option to choose a PPO or managed care package. A few years ago it cost the State employee more for managed care than PPO. Selecting the PPO would leave you at risk of if a hospitalization were to take place, of paying more. However, if your family stayed healthy, it was a better option in order to save money. That is not generally the case; it's usually that you get more with a managed care plan, with less out-of-pocket and less risk.

There's been an assumption that the ABD population does not want managed care. Most people want total control, but they know how difficult it is to navigate the system and we want to present them with the option; and to monitor what the selection process is. We are getting political pressure from providers-e they're very frustrated with the recipients due to the lack of orchestrated care. We are also getting political pressure from the advocacy groups there is fear and anxiety any time around trying to control someone's access to healthcare.

There are more options other than on Slide 13, the bottom bullet (managed care). One option is to maintain the status quo-do nothing. There is primary care case management, which we had decades ago. There are special needs plans coming out as a result of the Medicare Modernization Act (MMA).

The special needs plans are where we will be seeing an influx. Sierra is planning to do a special needs plan and has certification from Medicare for the end-stage renal disease population. Molina is another MCO that are going to be taking the Medicare population and managing the special needs (higher cost) people in that population. Many states are looking at integrating the Medicaid population because they're focusing on the dual-eligible (Medicare-Medicaid) population. If we integrated some of our payments to them, then they would take over and do the management of the Medicaid population. Because we have to do the budget forecasting a year in advance, this was not a significant issue a year ago. So we have nothing in the works to share with the special needs plans in covering the recipients.

Mr. Rundlet asked Ms. Wherry if the best practices out there now reflected on this page (slide 13?); and regarding the comment made regarding the "ongoing issue" of the small percentage of people using the vast number of dollars-what is the reason we're not ready for this year, but looking for next year (to be able to forecast better).

Ms. Wherry stated that one of the challenges for Nevada Medicaid is that Nevada State Legislature only meets every two years. The special needs plans came out of the MMA. In 2006 the big pressure to implement the regulations that came from the MMA was Medicare Part D. For states that have annual Legislature, they have the opportunity to quickly turn around and tell their Legislature what they need to integrate what these managed care providers for this specific population. We'll have to wait until 2009 for that opportunity.

Mr. Rundlet stated that previously a physician of Centers for Disease Control (CDC) stated the number one priority of the presidential Administration was Chronic Disease. Does some of what we're talking about come under chronic disease?

Ms. Wherry answered no, but typically what happens is if CDC has initiatives, or regulations that need to be complied with it's the Division of Health that would be responsible for those, because they're responsible for the health of the State.

Mr. Rundlet stated there should be built into the program a contract between the recipient and whoever is paying, in this case, the State of Nevada. Are there plans to incorporate some sort of contract with the recipients that states that the State will do specific things as well as the recipient, one that makes the recipient commit to bettering their care as well.

Ms. Wherry answered that with the Medicaid population, Nevada Medicaid has to comply with the federal rules. Medicaid is an entitlement program; the recipients are entitled to their services. We have to assure the recipients have the right to choose whether they want to be a part of the plan, then they have the right to choose what providers they wish to use on the panel. Except for that federal language around that "lock in" program mentioned earlier, which is limited, we have to assure the recipients have true freedom of choice of providers. That's part of what has led us to where we are today, in that we cannot control their access. Per the Medicaid Services Manual (MSM), Chapter 100, recipients have to be free to choose who they want to, but at the same time, providers can refuse to see the recipients. This adds to what makes it difficult to manage.

There are staff that have participated in the Center for Health Care Strategies Institute on managed care for the ABD population and are going to a second institute in February (2007) to follow through. What we are trying to glean from the states that have been more progressive in this is what lessons can be learned from their experience so we can start off with the strongest position possible. One of the benefits of being last is learning from someone else's mistakes.

Dr. Fiore asked Ms. Wherry if the PCCM (?) and special needs models were rejected?

Ms. Wherry answered that Nevada Medicaid is not looking and don't have a budget proposal specifically for the federal definition of PCCM (?); however Medicaid is looking at and hope to get funding to have a

side-by-side care management /care coordination program for the ABD population, primarily focusing up front on the high cost individual that Medicaid can identify through our claims processing system. Today we are just focusing on the managed care component as it's the more controversial because of the ambiance around managed care nationally. It would still be a fee-for-service program; we would pay a per-member-per-month rate to which ever provider is for the care management. We would be able to draw down from the Federal government a 50% match because we're administering our program efficiently and properly, but we wouldn't be able to get some of the same benefits at the safe fixed rate that we would get with the managed care plan. The special needs plans are happening whether we are a part of it or not. One of Nevada Medicaid's goals over time, and again, a year from now we'll be developing our budget concepts for the 2009 session and we'll have one more year to see how the other states have fully integrated Medicaid with the special needs plans are performing and hopefully be able to have some national experience to determine where to get the better bang for your buck-with managed care that Medicaid runs and supervises, or with the Medicare-Medicaid special needs plans.

Mr. Fiore asked if there is more money available from the Federal government if we go to managed care.

Ms. Wherry states the price is the same, but it's a fixed cost; whereas in the care management design it's not. Medicaid is still paying all the fee-for-service claims the vendor has no risk. For the utilization management functions, (we'll be going out to bid for this if we get the funding for it) when we go out to bid, for example, First Health bid on the contract and won, they would continue to retain the utilization management function for that population. However, if we go out to bid and First Health was not a selected vendor, or didn't participate in the procurement process, then the new vendor may take over the utilization management function. In that case, we could get a 75% match from the Federal government for those activities, if they're being performed by a nurse or physician.

Nevada Medicaid's recommendations are that we all agree to work together for the recipient's benefit. On the last page we're asking for the Committee to give us their feedback over the next several weeks about what they feel the challenges will be for implementation. In terms of working together, it's not just with the MCAC, it's also working together with Nevada Medicaid's sister agencies-the Division for Aging Services (DAS) for example. DAS has 3 home and community-based services waivers they operate. One of those is group care, one assisted living. Neither of which should be impacted. There is the Community Home Initiative Program (CHIP) waiver; however, that is the program for the elderly. DAS employs a large number of Social Workers and nurses who do case management for their population. Nevada Medicaid needs to partner with DAS. Our intent for the managed care program for this pilot, voluntary program is not to tap into the dual-eligible population that could maybe be served with the special needs plan; to not tap into the people already on a waiver who have extended services that help keep them in the community. Our intent is more to go after the people who don't have a waiver, don't have any management at all, who are just out there floundering at great cost.

Mr. Rundlet asked if Nevada Medicaid was going to seek input from different state medical associations.

Ms. Wherry stated yes, on a local perspective, it's one of the things they are looking at the MCAC to look at. Would the board be willing to do provider and recipient workshops where we try and pull in people that will be affected by any regulatory change to ask their opinion; what should be included in the procurement; what should the contract be very solid on; is there some sense of what the performance measures should be, etc.

When we bring up a managed care plan, or any type of organized system of delivery of care model, we try and do what we call a "readiness review". Part of that review is to determine, for example, based on the number of recipients that are expected to be covered, how many primary care physicians are there? The national statistics would say there needs to be one full-time equivalent physician for 1000 recipients. If we are covering pregnant women, how many OBGYN's should be on the panel and how many recipients can they take into their practice? These are the types of issues that would be helpful to hear back from the provider community.

We also plan to work with the Division of Mental Health and Developmental Services (MHDS), another sister agency because they serve the mentally ill population and many of those people tend to be some of our highest users of health care. The idea is not to step on the toes of their mental health management, but to figure out how a managed care vendor would be expected to work with their state partners; which entity takes up which cause of their individual care needs. Would the state relinquish the mental health care needs to the vendor, or would the vendor work with the state so the vendors take in the medical needs and the state partner takes in the mental health needs. These are things to look at, but may not be resolved when we finally start because you "live in" to a process. Sometimes you learn what works best during the implementation of that process.

We are interested in any feedback the committee can provide us, what they think may be some barriers that we might expect, or what the vendor might expect. We know the physician community in Reno operates very differently than the physician community operates down in Las Vegas. How we can reach out and to whom in terms of the open enrollment period to capture those people who can benefit the most from this. If we are able to procure this, one of the Federal requirements is that any marketing materials the managed care plan develops have to come through the MCAC before being released to the recipients.

(unknown person) asked if there was a medical care organization interested in doing this in the state?

Ms. Wherry answered yes, Anthem would love to do managed care for the ABD population and would be willing to do it and even take the risk in a voluntary scenario.

(unknown person) asked would they be able to do it statewide, or would it be bifurcated like the rules in the urban communities?

Ms. Wherry answered that the intent would be to do something more like with the TANF and CHAP populations. Because it's a new program, we need to test the waters. Nevada Medicaid takes a huge amount of risk in the startup of the program-as the plan does as well. There is no guarantee what kind of volume we'll have in a voluntary market. The intent is to start it off in the Las Vegas/Clark County area where there is a larger volume of people and far greater activity going on in the health care delivery system. If we're successful, we would then move it to the Washoe County area. Going into the rural areas is a challenge, we've had a challenge just trying to collect significant information to expand managed care for the TANF and CHAP population. The Federal rules are such that the freedom of choice she spoke to before, if we are going to only have one plan, it must be voluntary. If we're going to have two plans in the same geographic location, then they can make managed care mandatory.

Because we want to start this voluntarily, it will be up to how well the plan markets and how well the recipients respond to that marketing. If it becomes successful and we believe it's the right thing to do we would go back and ask for political support to expand and make it mandatory, but that is way down the road.

(unknown person) stated that it seemed sensible that a pilot project as this would be looked at and used in comparison to see if there is a beneficial cost analysis and if the recipients are receiving improved health care. He recommends coming back with something like this because it's such a risk in doing this, you may as well do it at a specific population and see if it's successful.

(same unknown person) asked Ms. Rosaschi in the discussion about having a meeting sooner than next June and discussing things to take for Legislature, his recollection is that the governor limits Mr. Willden about what he can bring to him and Mr. Willden limits things Mr. Duarte can bring to Mr. Willden. They themselves don't have access to the Legislature except through the Executive Branch, so we need to be very cautious about extending ourselves to the point where we would anticipate Mr. Duarte or members of this organization have the ability to carry forth for the Committee any political agenda that might

suggest the Committee wants to do something. This is just an advisory comment because they have those limitations and we need to be practical and pragmatic about the political influence that the administration has.

Ms. Wherry spoke to the biennial process, and there is a much longer period of time between sessions where the committees do a significant amount of work in preparation for the next session. It is anticipated that the Committee would be able to prepare legislative bills for the Legislature to contend with-possibly above and beyond what is presented in DHCFP's budget. This is an opportunity for the Committee to make changes and learn more about Medicaid.

Dr. Fiore asked how we can prevent the MCO from discouraging recipients from seeking healthcare; after all, no health care is the cheapest health care. He also wanted to know the MCO's profit margin.

Ms. Wherry explained that there is a cap to their profit margin and an actuarial contract. If the MCO's profit margin became too great, we would reduce our per-member-per month and reduce payment to the MCO, thus discouraging that activity.

Because this is an entitlement program-DHCFP receives a 50% match from the federal government, thus we have a different financial motivator than a commercial payer would. Medicaid is self-contained economic situation and doesn't have the same economic drivers as a commercial market. This is part of the contractual accountability we have with the plan. One risk of having a voluntary program with only one plan is it doesn't offer choices of other plans. For instance, we had one plan that didn't survive the procurement process this year and many recipients dropped from that plan's rolls and onto another vendor's, most likely due to better managed care. DHCFP would like to see this be a mandatory market because of that opportunity; the consumer makes the choice. If the recipient is unhappy, however, they can drop from the plan.

Mr. Rundlet questioned what DHCFP has learned with regards to preventative measures for getting the numbers down for the ABD population (referring to the 56% of Medicaid spending).

Ms. Wherry answered that DHCFP collaborates with the Health Division. DHCFP has asked their staff to attend the monthly managed care meetings for these issues. The Health Division deals with the state as an entire population, whereas DHCFP deals only with the defined Medicaid recipient population; and DHCFP wants to make sure the MCO works closely with the Health Division for preventative care, vaccinations, etc.

Mr. Rundlet asked if that could be built into the Request for Proposal (RFP).

Ms. Wherry said that has been spoken of in the procurement process. DHCFP expects the MCO's to participate in prevention, but they can only do that to the extent that the Medicaid population allows it-we have no control over recipient behavior. For example, DHCFP provides transportation to all medical services for our entire population to remove the excuse that they can't get to their appointments.

Dr. Fiore stated this is more of a public health issue, as diabetes, blindness, COPD, etc., are all mostly preventable. This doesn't sound like something Medicaid can deal with now.

Mr. Rundlet agreed, stating that when he heard "blind", he immediately thought of diabetics. The Native population is at 700% greater. He said one of the things that they do (Native population?) is build into that a managed care for the diabetic-something as an example that he would like to see built into the RFP, because if the MCO just takes the money and manage the prescriptions and doctor visits, they should be managed on a diagnostic basis, because each diagnosis may be a bit different from the other. He feels that into the RFP there are things you can build into the care of the disabled or blind person.

Ms. Wherry stated that we do have diabetes as one of the expectations of the procurement process for even the TANF and CHAP population that is being managed. DHCFP doesn't want the diabetic recipients to get the complications that would set them up for more compromised health care problems. Again, MCO's have an incentive here. If they have a diabetic and they're not taking care of them, they're costs will be quite large, and the MCO's bear the costs. She mentions a bidder on a contract for TANF and CHAP but was not awarded offered to cover dental for pregnant women in their proposal. This was at no cost to the state, but they knew that if they addressed the oral care of pregnant women and the potential for premature births because of premature labor due to poor oral hygiene, they would save money. It's a false belief to think that the best way to save money is by not providing care. DHCFP is really trying to reach out to the national market to bring in very strong competitors to the Nevada market because the Nevada market is very immature compared to other states.

Mr. Stoker asked when a contract is awarded, is there a contractual time agreement where they must continue to be under contract with Nevada Medicaid?

Ms. Wherry stated it's usually a 2 year contract. DHCFP may have a provision that allows the specific procurement for 2 more years. After the first 2 years it's very costly to procure a contract and then start up the process. The managed care plan must develop a claims processing system that mimics DHCFP's rules. They have to create the provider network if they are new to Nevada. This is very expensive from a health care cost perspective to have a rapid turnover in the procurement process. DHCFP works hard to have an objective committee and criteria to determine who should be awarded the contract.

Mr. Stoker asked if in other states historically if there was much turnover

Ms. Wherry says it's back and forth depending on what is happening nationally. The state of Oregon for instance who procured many MCO contracts and may have had 3 – 5 vendors at one time and finally realized through experience how difficult it was to manage and keep all the vendors on the same page and finally reduced the number of MCO's. It depends also if they're finding new performance measures coming up, new evidence-based practices they want to incorporate, these may be a driver for why they want to look at change.

Dr. Fiore stated that the incentive for the insurance company is that the pay off often isn't bought until 5 or 10 years later. Some of them, the (unintelligible) patients/clients will actually have a payoff earlier. One of the problems with our health care system is preventative medicine pays the next insurer that gets the contract 5 years later when you have prevented the outcome and it's difficult to incentivize. Medicaid is at an advantage because they have so many requirements that must be met.

Ms. Wherry agreed this was an excellent point.

Mr. Blake asked if DHCFP was looking at specific medication reviews because he knows Ms. Wherry was talking about the poly pharmacy that was involved, especially with the senior population-specifically the individualized medication reviews outside just the community pharmacy.

Ms. Wherry explained that the way the MCO plans tend to operate is they have the liberty of creating their own formulary, although they have to comply with Federal and State requirements. It's going to come down to freedom of choice of providers. The managed care plans must have a sufficient network to assure access to the recipient and also geographically locate providers based on the recipient population, which is in the best interest of the Division since their transportation is covered by Medicaid.

Mr. Blake reiterated that he was interested in outsourcing medication reviews overall.

Ms. Wherry stated that in general she didn't believe managed care plans would do that because they have contracts throughout the U.S; and they have their own pharmacy benefit management program.

They may subcontract their pharmacy benefit management to another vendor, however. It's up to each plan how they choose to do that. The do have some Nevada statutory requirements they have to meet.

There were no comments from Las Vegas or Carson City.

Agenda VI

John Liveratti, Chief of Compliance, and Liason for the Medical Care Advisory Committee, returned to a previous discussion regarding the definition of Medical Necessity. This was most recently discussed at the MCAC meeting on February 17, 2005. Mr. Liveratti received a request in Fall of 2006 from Nevada Disability Advocacy and Law Center (NDALC) when the discussion on the definition might resume. Mr. Liveratti determined the best forum would be in front of the MCAC. Mr. Liveratti and the Law Center provided documents for the Committee to review. He has his staff available and also DHCFP's health management vendor available to answer questions. Janet with the NDALC was also available in Las Vegas.

Ms. Rosaschi said there is a process by which an individual that was denied something they believe was medically necessary to go through and the process is not always clear. Often when a denial is made, which is usually by a third party, there is a hearings process to determine if what they are seeking is going to be rewarded. Through that process, often the information is then researched and elevated up through the administrative process and the client is often awarded services sought. As a result, maybe the definition of medical necessity is something that needs to be looked at.

Janet Belcove-Shalin, Civil Rights attorney from the Nevada Disability Advocacy and Law Center, brought up proposed recommendations which bear on the definition of medical necessity and the ways in which certain sections of the Medicaid Services Manual (MSM) would appear to undercut the definition as it is applied to any particular client. She had previously submitted a 3 page document regarding this issue.

Dr. Fiore stated he did not know how big of a problem this is and would like some data regarding how often there are there appeals to the decision of medical necessity-when things are denied, how long does the hearings process take, and what is the outcome. If we're finding that 80% of the appeals are upheld and the issue was found to be medically necessary, obviously there is an issue with interpretation with the definition of medical necessity. If one the other hand, if most of the time the decision to deny was deemed appropriate, that opens up another question. The definition may not be as good as it could be.

Ms. Wherry explained the process. A recipient goes to a health care provider and requests a service. If the service requires a prior authorization, the provider contacts the utilization management company, First Health, and asks for the prior authorization and asks to be able to assure payment for the service provided. First Health looks at DHCFP's regulations and criteria and what we have validated with them to be a national standard. They use InterQual criteria, for example, for many of the services being delivered. Otherwise they may use Medicare criteria, or they use specified DHCFP criteria as to whether something meets the definition of medical necessity, and that is unique to that specific service. If First Health does not get adequate documentation from the provider to substantiate their ability to answer those questions, then they are going to deny access to the service. Some services are denied due to adequate information not being provided.

At that time a Notice of Decision (NOD) would be sent out to the recipient. If the provider has indeed provided sufficient documentation, and it does not meet the requirements, then First Health would deny the service. This is all an automated process. First Health staff in Reno, Las Vegas and Virginia would go into the claims processing system and say that the service request has been denied. The claims processing system then automatically generates a letter with a NOD that goes out to every recipient. These are Federal requirements that must be met within a specified time period. Some of that time

period is defined by the Federal regulations; for Nevada that time period has been specified through a judicial decision. The State Department of Health and Human Services was sued and we now have to make a decision within 21 business days from the date the request for service was made. Most of the decisions with First Health are made within 2 – 5 business days. When the NOD is sent out to the recipient the recipient has 90 days to request a fair hearing.

Ms. Wherry stated that she feels the data that would be relevant for Dr. Fiore is how many NOD's are sent out. That is the important base.

Ms. Wherry asked Mr. Shaw, the Account Manager for First Health whether they would be able to stipulate or specify within their data request whether they can isolate those that were denied for lack of sufficient documentation or because they didn't do the request timely-what DHCFP refers to as technical denial versus those that were true denials based on medical necessity. If First Health and DHCFP can supply the data to distinguish the technical denials from the medical necessity denials, then DHCFP can also give Dr. Fiore data to show how many fair hearings requests DHCFP receives in a month, as well as how many fair hearings actually occur. This can also be done by service type. So it would be a generic over-all, how many requests for dental services that are denied vs. Durable Medical Equipment (DME) that were denied. That would give a better sense as to the types that have a higher rate of denial compared to others.

Dr. Fiore also asked that the outcome of the fair hearings statistics also be included, whether the decision was upheld, etc. That would need to be limited to a certain time period, for example, six months worth of data or maybe a year's worth. This will take some time to get the information.

Ms. Rosaschi asked if there is not a process where the client and/or advocate can meet with staff and work through these types of issues to avoid going to hearing.

Ms. Wherry said that the point of making sure it is understood how many people request a fair hearing vs. those who actually go to fair hearing. There are pre-hearing conference calls, where the recipient is helped to understand what the hearing is about. The hearing is simply about whether or not Nevada Medicaid regulations were followed or not. It's not about are the regulations fair. Once the recipient has a better understanding of the regulations and what the hearing may approve or not, they may decide to not pursue the hearing. Or also throughout the process, additional information may be procured that was not provided to the utilization company. Through that additional information, there may be internal dialogue and problem solving to say that based on the new information, the services are now approved.

With the Federal requirement for the Early Periodic Screening Diagnosis and Treatment (EPSDT) population, First Health understands the EPSDT rules, but they sometimes struggle with whether or not it meets Medicaid's medical necessity. DHCFP has staff responsible for policies and the process of keeping them current with what is happening in the medical market at that point in time. There may be times where DHCFP says that this is an EPSDT situation and it needs to be covered, regardless of whether it's in the State Plan, but there is sufficient documentation, so it will be covered-whether it's a heart transplant or heart/lung transplant that is normally not cover under Medicaid. There are extenuating circumstances where DHCFP may make an administrative decision before the recipient goes to a hearing. It is very rare that after the hearing process that the decision would be overturned.

(Illegible; change of tape)

Ms. Wherry continued that if the prior authorization requirement was removed for dentures, for example, if DHCFP is paying more to the vendor to do a prior authorization, then DHCFP is saving in denials, then why go through a prior authorization process? DHCFP often changes regulations to say they don't perceive a lot of abuse, so they remove the prior authorization requirement. Then the denial rates go down because of the change in regulations.

Dr. Fiore asked about imaging services, that from a clinician's point of view, getting authorization for imaging has been challenging. Is that a big denial area?

Ms. Wherry responded that she didn't think most recipients understood the consequences of not having that service provided them, and that is between the provider and the recipient. It's not the recipient that requests the service, but the provider. If the provider gets a denial from First Health-and there are regulations that say the denial can be appealed; a reconsideration can be requested. Anytime a nurse at First Health gives a denial, it has to go through an internal medical review at First Health. Any time a service is denied, the physicians at First Health review that denial before it's given to the provider. Then the provider can ask for a reconsideration. At this time, they may provide additional documentation, request a peer-to-peer call with a physician at First Health to state their case. There are many steps that occur before the provider tells the recipient they were denied by First Health. The denial will have been put into the computer system and the recipient will get a letter of denial, possibly before the provider is able to tell the recipient.

Mr. Rundlet is wondering if the definition of medical necessity being used currently is something set in stone or changes and evolves over time.

Ms. Wherry answered that the reason this is on the agenda today is as a follow-up to the question posed from NDALC. During Mr. Duarte's introduction to this meeting as to what he's looking to the board for is the board's active engagement in Nevada Medicaid's rules and regulations. As the board is comprised of providers who are out there and are the closest to the recipients as well as the ramifications of Nevada Medicaid's regulations. Therefore, the board's input and feedback into Nevada Medicaid's process is valued, and why the board is being asked to look into the concern raised by NDALC for more immediate dialogue. Although any member of the board himself could have brought this to the board as a concern or issue if experiencing something or hearing something for themselves out in the general Medicaid market about some of Nevada Medicaid's restrictions or definitions.

Ms. Wherry stated this is basically the only complaint that has been received. DHCFP can ask First Health if they have any problems in this area, but most of that would show up on the fair hearings documentation. She believes it mostly revolves around DME. For example, a drug may have been developed for a specific diagnosis or disease and over time gets experimented with in other areas and used for another purpose than what was originally intended, and the same thing can happen with DME. It's a dynamic process that DHCFP is constantly trying to respond to. People may ask for the Cadillac of wheelchairs and the policy states we don't pay for deluxe, we pay for what is medically necessary. This is not just for the wheelchair, but also for any parts needed for the wheelchair separately, that also must be requested with a prior authorization and paid for by Medicaid.

Mr. Macdonald clarified that there appeared to be two recommendations here which mean essentially getting rid of a couple of exclusionary lists. Can Medicaid advise the Committee as to what affect these recommendations would have on the agency in terms of dollars and cents or utilization. What does this mean to the recipient, can they get the Cadillac of wheelchairs?

Ms. Wherry said for example, DME, if DHCFP modifies the language pertaining to DME, (which is always a challenge because there may be court documents that uphold what is believed by DHCFP and what the premise is based on; but there may be Federal guidelines that are different. Or there may be medical standards that are revolving that may influence that and it's always a challenge for DHCFP to keep the chapters current, it's a very laborious process to get a chapter to a public hearing and approved and kept updated. If DHCFP were to change the coverage definition, for example, of things in the past we've said are not covered benefits, probably the rebound would be that there would be more denials. Because in the past DHCFP has said "this is an excluded-coverage item, you cannot even attempt to get it", whereas if we change that language, the door may be opened for people to say, "it doesn't say I *can't* have it..." and so there may be more requests coming for things that they we're going to have to go back and look at-what are the medical criteria for that. Often Medicare is the first payer, Medicaid the

secondary payer and if Medicare made a denial, then Medicaid may uphold that denial and not overturn it because DHCFP would then pay 100% of the cost. Thus, this is a very dynamic situation, and she can't project it's going to mean that DHCFP is going to have to pay more money for medical expenditure, but it may mean that DHCFP will have to pay more money for the fair hearings and administrative oversight.

Ms. Belcove-Shalin reiterated that the purpose (word unknown used) for reviewing the definition of medical necessity is (not) because a client wants the Cadillac of all wheelchairs, but because the client's basic medical needs are not being met, and If they're not being met, down the line, it will cost the State more money. This definition is quite critical because in some ways it's the gatekeeper to whether or not individuals get services or whether they don't. That's why the definition of medical necessity needs to evolve and needs to be revised and reviewed to see which terms may be ambiguous and how the *basic* medical needs of the recipients can be met. As well, there may be a number of reasons why, at the fair hearing process, First Health's decision is upheld. It may be that many clients don't have representation except their own and are unable to make the best argument for their case; they may not be able to have expert witnesses testifying on their behalf. At a fair hearing, the State always has an attorney present (Gabe Lither confirms he believes this to be so) and there is no attorney representing the recipient requesting an appeal of First Health's decision.
Ms. Belcove-Shalin's organization, NDALC, has been very successful representing clients and that could be for a variety of reasons. However, the situation is more complex than one might initially think.

Ms. Rosaschi stated that in a hearings process, usually there's an exhibit prepared. Often it is by the State agency that then walks everyone through it at the beginning of the hearing. She assumes it is what was requested, what was gathered and that the decision to deny was based on some policy. Is this a correct statement?

Ms. Belcove-Shalin asked if that was a question for someone from the State.

Ms. Rosaschi said she was asking Ms. Belcove-Shalin, but that the audience in Carson City were all nodding their heads yes, and she went on to continue with what she assumes is the process. She said that then the Hearing's Officer makes a decision based on the facts presented before him/her during the hearing, looking at the definition of medical necessity and then what was requested, the process the recipient went through, and they make a hearing decision based on the policy.

Ms. Belcove-Shalin stated that briefs can be submitted along with attachments and exhibits. They can also have witnesses, somewhat like a mini trial. They don't need to be lengthy, some have lasted up to four hours.

Ms. Rosaschi asked Ms. Belcove-Shalin that based on her anecdotal history, if a client is trying to present their case and does not have legal representation-obviously they are not as articulate as an attorney can be-and so they are just trying to appeal to the Hearings Officer based on a motion, demonstrating their need for service based on medical necessity. Ms. Rosaschi is just trying to look for something the Committee can work with based on the word-for-word definition to help the process. She's struggling with the "word-smithing" process.

Ms. Belcove-Shalin said that what typically happens is the State will present a case that says the particular item (using DME as example, as that is what the hearings are usually about) is not medically necessary due to A., B., and C... reasons. That is what is challenged by the recipient that is appealing the denial of the PAR. In challenging that, that's when the witnesses, attachments and exhibits come into play.

Mr. Rundlet asked, since this is important language that needs to be rectified, that you (Ms. Belcove-Shalin or Ms. Rosaschi or the Committee?) work with the Medicaid office to see where the common

language can be found. He asked Ms. Wherry if she believed that there is room to improve the current language or is the position of DHCFP that it is as it should be currently, with no changes.

Ms. Wherry said that her perception from the Administrator, Charles Duarte, is that this is what we've put out there for the MCAC to churn. If DHCFP felt there was a problem with the definition of medical necessity, they would have taken the responsibility to change it. But when an issue is raised, then we're going to entertain that issue. That's where we want to use the medical experience of the MCAC and opinions to discern, does the Committee believe there is an issue, and if so, what are the Committee's recommendations for ways DHCFP can improve upon that language.

Mr. Fiore (reading from a document transcriber is unfamiliar with) on page 3 one of the recommendations is, "expunge from the MSN Exclusionary List, at the very least, frame them in a manner consonant with the CMS policy." This is a policy interpretation. Is it truly out of compliance with the CMS policy, this is something DHCFP may want to look into.

Ms. Wherry agreed. There is some corrective language that will be changing in the Medicaid chapters.

Mr. Fiore asked Ms. Wherry if she could work with the legal office to come up with common language and areas of contested language he would feel more comfortable with, rather than saying one office believes it should be this way and another believes it should be that way and then the Committee can make an informed recommendation. Looking at it at this time doesn't make a lot of sense, although DHCFP may agree with some of the changes or work out a compromise.

Ms. Wherry, speaking to Mr. Duarte the best she can, but she can't guarantee that she's capturing his intent or request. Her perception is that there are some things that DHCFP will be changing in the DME Chapter 1300. There is a turnover in staff, things that may have come out of CMS 10 years ago, staff may have interpreted it at that time and now the interpretation may have changed. DHCFP will take responsibility for that, but the Committee could still churn on, regardless of if they have data, regarding the number of fair hearings, what the hearings are about, and so on, are generic to the proposed definition that NDALC has provided on that the bottom of the first page (of document the transcriber is unfamiliar with). NDALC actually had a proposal about what they thought the language should be vs. what DHCFP's language is. There are many State Medicaid programs that have much more restrictive language than Nevada does. Ms. Wherry has also had her own discussions with First Health through hearings situations to say that staff really need apply critical thinking skills and not necessarily be absolute. There is a risk for them if they do that, and make sure that we're making our decisions based on that individual need of the recipient. But DHCFP is different than many Medicaid programs. If utilization management companies were interviewed they would tell you that Medicaid says to deny everything that can possibly be denied, because that's how to contain costs. That is not Nevada Medicaid's attitude. Nevada Medicaid's attitude is what can we reasonably cover, realizing that we're drawing down a 50% minimum, 50% Federal match, and with the Federal Government agree with our decision to spend their money, what can we reasonably cover that meets the medical necessity definition; that meets requirements of the chapter; and keeps the recipient at the lowest level of care possible, with regard to institutional vs. home and community-based care. Fundamentally, that is DHCFP's philosophy and it's much more liberal than other State Medicaid programs.

Mr. Rundlet asked Ms. Wherry if some of the concerns were more money motivated than following good practices of medical care within our community, however we define community.

Ms. Wherry doesn't think decisions are necessarily money motivated, but based on the endowment that comes from the public, to spend taxpayer's dollars prudently and wisely. Ms. Wherry goes and accesses care as a consumer in the health care industry and a particular provider may just read her the riot act with how angry they are with the Medicaid population because of how they perceive the population abusing their rights to health care. Ms. Wherry believes DHCFP makes pretty good decisions.

Mr. Rundlet reiterated asking for the in formation Dr. Fiore asked for previously regarding the statistics because Mr. Rundlet's concern is less on the money side and he wants to make sure the providers are getting what they believe is in the best interest of the patient that they are obligated to take care of. The money part can be taken care of afterwards. Mr. Rundlet thinks some of the data that Dr. Fiore mentioned would help the Committee define it more.

Ms. Wherry said one of the other pieces of data to provide to the Committee is how many requests for reconsideration does First Health get. That would show the provider's opinion regardless of the recipient's opinion, as to whether they felt that medical necessity was demonstrable or not.

Dr. Schoop, Medical Director of First Health Services called into the meeting by phone. He wanted to make clear that First Health would never do anything to encumber the processes in place that are the right of the recipient, providers or community in accessing appeals and fair hearings. First Health follows the process much as Ms. Wherry has described to the letter, but in addition to that, when First Health sees repeated requests and denials around a given service, especially if it is coming from a specific provider, First Health makes an effort to engage that provider with the physicians at First Health and even national experts at times in the field to try to understand what is driving the request to not be compatible with the criteria First Health has. There is no incentive for First Health to take things to fair hearings for to deny a claim. First Health is simply here to administer the State's Medicaid policies. If DHCFP feels there is an issue with regards to medical necessity or a particular procedure, given the standards of care in other medical arenas, First Health does bring that to the attention of DHCFP. Dr. Schoop has in the past had discussions with Mr. Duarte and Ms. Wherry and others, and alterations of policy do take place at times if it seems appropriate. Today's discussion is more in the theoretical and without looking at actual numbers and cases, we are speculating about whether or not medical necessity even exists and should anything ever go to fair hearing or not. Fair hearing is a place of last resort where arguments do fall between the cracks or fall outside of any clear definition and have an arena to be aired. First Health remains open and at the bequest of DHCFP to be supportive in any clarification of definition, review of criteria or how it's being administered and would like to reach a fair, just and medically appropriate determination in every case.

Ms. Wherry responded to the point that Dr. Schoop made about the fact that First Health has no incentive to say no, they're simply doing what Medicaid asked them to do-this is extremely well taken, as well as the attempt to find out also, what is the most current practice, because it is a dynamic process. DHCFP could right a policy today, and tomorrow the FDA or another entity can come along and say now this is approved for X, Y, & Z, whereas DHCFP said it was only approved for A, B & C. That is a dynamic process that DHCFP will never be able to always be on top of. Up front, things that go around, recipient accessing care, on the back end, after claims are paid we also have the process where we look at-from a surveillance/utilization and review perspective-what kind of abuse is happening out there in the system? Sometimes the policies may be in response to the fact that DHCFP has uncovered a significant amount of abuse. DHCFP tries very hard to diminish the administrative hassle factor the providers have to go through because there is a cost to that. We're driving up the cost of the provider's business, which is ultimately going to drive up the rate DHCFP will have to pay the provider to stay in business. DHCFP really tries to balance the equation of that administrative hassle factor with when do we request a prior authorization and when do we just allow free access to an indefinite number of services. That is something where the Committee's professional expertise is also valued. If the Committee knows that there are quantity limitations on a specific product or service and think that that is meaningless, DHCFP would appreciate knowing that because DHCFP doesn't want to pay a high dollar amount for a prior authorization for something that doesn't really reap any kind of benefit. On the other hand, it may be discovered there is a significant amount of abuse for example, ultrasounds for pregnant women. At that time we may have to go back and look at the policy and say hey, we're discovering fraud and we need to tighten our belt in order to be able to contain that. The Federal government expects us to do that, and if it hit the press, the public would as well. DHCFP walks a very fine line in how we develop what we do and what we allow for people. If an assessment is done of the community, there are many times when people are frustrated because they perceive that Nevada Medicaid recipients have a richer benefit than

people who pay out of pocket for that benefit. DHCFP tries to do what is we believe is right for the consumer and right for the providers and put blinders on to some of the other arguments.

Ms. Rosaschi asked for questions or comments.

There were no questions or comments.

Ms. Rosaschi summed up what she understood was stated. DHCFP will look at the definition and that DHCFP believes there might be some room to update the definition of medically necessary based on what was stated. She heard Dr. Fiore made a recommendation that perhaps there's some suggested language that can be worked with NDALC on; also that there is a request for additional information. She would like to see this on the agenda to continue the dialogue.

Agenda VII

This was fine with the Committee. There were no more questions or comments and the hearing was closed and opened for public comment. There were no comments.

Agenda VIII

Ms. Rosaschi adjourned the meeting at 11:38 a.m.

NEVADA DISABILITY ADVOCACY & LAW CENTER

Nevada's Federally-Mandated Protection and Advocacy System for Individuals with Disabilities

June 12, 2007

John Liveratti
Chief, Compliance
Division of Health Care Financing and Policy
1100 E. William Street
Carson City, NV 89701
Fax: (775)687-3893

Dear Mr. Liveratti:

At the January '07 MCAC meeting I raised a number of concerns for consideration by MCAC members with regard to "medical necessity." These concerns pertained to the way in which the Nevada Medicaid Services Manual ("MSM") delineated medical necessity (§ 102.80) and also, substituted alternative criteria in lieu of a medical necessity standard.

Per the suggestion of MCAC members to provide the committee with text of the proposed changes, I am enclosing the following: (A) A revised definition of medical necessity and (B) two suggestions pertaining to Appendix A: Non-covered Items, Chapter 1300: DME, Disposable Supplies and Supplements. I continue to urge the Committee to: (C) amend MSM 1300 in order to delete the exclusion of "rehabilitation"and (D) scrap the "Respiratory Equipment Therapy" guidelines under the "DME Coverage and Limitations Guidelines." Also enclosed is a brief legal rationale for these changes.

Thank you for disseminating this document to the Committee.

Sincerely,

Janet S. Belcove-Shalin, Esq.

Enclosures:

✔ MAIN OFFICE
6039 Eldora Avenue, Suite C, Box 3, Las Vegas, NV 89146
702/ 257-8150 (Telephone) 257-8160 (TTY)
888/ 349-3843 (Toll Free) 257-8170 (Fax)
ndalc@ndalclv.org (Email) www.ndalc.org (Website)

NORTHERN OFFICE
1311 North McCarran Blvd, Suite 106, Sparks, NV 89431
775/ 333-7878 (Telephone) 788-7824 (TTY)
800/ 992-5715 (Toll Free) 788-7825 (Fax)
reno@ndalc.org (Email) www.ndalc.org (Website)

A.

DEFINITION OF MEDICAL NECESSITY (102.80) FOR THE STATE OF NEVADA

The definition of medical necessity is flawed. I propose to change it from:

To be considered a medical necessity (medically necessary), items and services must have established as safe and effective as determined by Nevada Medicaid. The items and services must be:

a. Consistent with the symptoms or diagnosis of the illness or injury under treatment.
b. Necessary and consistent with generally accepted professional medical standard (i.e., not experimental or investigational).
c. Not furnished for the convenience of the recipient, the attending physician, the caregiver, or to the physician supplier.
d. Furnished at the most appropriate level that can be provided safely and effectively to the recipient. Medicaid will only cover items and services that are appropriate and necessary for the diagnosis or treatment of an illness or an injury, or to improve the functioning of a malformed body part.

to:

A medically necessary service is defined as a covered service that:

1. Meets professionally recognized standards of acceptable medical care.
2. Is consistent with the symptoms of the recipient's condition (physical or mental illness, injury, malformed body part, disease, infection, or disability).
3. Is furnished at the appropriate level for the age and health status of the individual.
4. Is delivered at the appropriate medical setting in a timely fashion.
5. Does not duplicate other services provided to the recipient.
6. Is not solely for the convenience of the recipient, the recipient's family, or provider.
7. Diagnoses a condition; prevents a condition from occurring; maintains an optimal level of health; corrects or diminishes the adverse effects of a condition; monitors a condition; alleviates pain and suffering; or improves or restores the functioning of a body part or system.

Legal Rationale:

Section 102.80(d) cites "to the diagnosis or treatment of an illness or an injury, or to improve the functioning of a malformed body part." A host of problems exist with this provision. For one, it excludes a great deal of preventive care that Medicaid authorizes (or in some instances, mandates) such as immunizations, lead blood tests, pap smears and mamograms. Furthermore, the provision could presumably exclude any service provided to monitor, but not treat, a patient's condition, such as the glucose monitoring of a diabetic patient. Moreover, it is unclear whether the passage "improve the functioning of a malformed body part" refers to rehabilitation, though a plain-language reading of the provision suggests that it does. Finally, the current definition of medical necessity neglects the alleviation of pain and suffering. Managing pain and suffering and offering rehabilitation services are not merely humanistic measures; these services assist the individual in obtaining and retaining capability for

independence and self-care. Title 42, Chapter 7, Subchapter XIX, § 1396(2) (see below for further explanation).

Section 102.80(d) also states that items and services must be "[f]urnished at the most appropriate level that can be provided safely and effectively to the recipient." The terms "safely" and "effectively" require some explanation. Are they to be understood as the terms of art used during clinical trials for new drugs and devices? If so, it is unclear how the MSM adapts the terms to determine the medical necessity of services (e.g., physician visits). Further problems exist: This usage could foreclose the coverage of services that reflect the consensus of the professional community regarding a particular disease or treatment but were not developed from determinations of safety and efficacy; this limitation could impede treatment or services to children and pregnant women who, for ethical and legal reasons, are rarely included in clinical trials; this limitation constrains the ability of health care providers to apply new research to Medicaid recipients before researchers complete their scientific studies.

B.

Appendix A: Non-covered Items, Chapter 1300:
DME, Disposable Supplies and Supplements

Appendix A: Non-covered Items, Chapter 1300: DME, Disposable Supplies and Supplements is an unlawful exclusionary list. I propose one of two courses of action:

1. Delete Appendix A: Non-covered Items.

2. If Nevada Medicaid chooses to maintain Appendix A: Non-covered Items, Medicaid must introduce the list with language that recognizes the limitations of exclusionary lists. For example:

   "Consonant with Medicaid policy (see CMS 1998 policy letter on "exclusive lists") Nevada Medicaid uses this list solely as an administrative convenience. Any request for DME is subject to a determination of medical necessity (MSM 102.80)."

Legal Rationale:
The law is clear on the subject of exclusionary lists. Lists subject to an absolute exclusion of non-appearing items or the inverse, lists of non-covered items, are unlawful. In 1998, HCFA (now called CMS) issued a policy letter to address the practice of state Medicaid agencies that published lists of pre-approved items. See enclosure: CMS 9/4/98 policy letter on "exclusive lists". This letter reiterated the intent of Medicaid and clarified the requirements for DME coverage: States may not arbitrarily exclude items from coverage based solely on diagnosis, type of illness, or condition; states may only use DMR formularies (i.e., approved lists) as an administrative convenience so long as the state provides a reasonable and meaningful procedure for requesting items not appearing on the approved list; the approved list and the process for seeking modifications and exceptions must be made available to all enrollees; a state's list of pre-approved items of DME should be viewed as an evolving document that should be periodically updated to reflect available technology. See T.L. v. Colo.Dept. of Health Care Policy and Financing, 42 P.3d 63 (Colo. App. 2001) in which the court struck down

the state Medicaid agency's list of excluded DME, significantly relying on the CMS 1998 policy letter. The T.L. Court held that Medicaid could not exclude a hot tub from coverage under all circumstances and without regard to medical necessity, as this is a violation of Title XIX of the Soc. Sec. Act. See also Esteban v. Cook, 77 F.Supp.2d 1256, (S.D. Fla. 1999) in which the court, citing the 1998 CMS letter, struck down a cost cap of $582 on wheelchairs for adult beneficiaries because the state Medicaid agency failed to provide a reasonable and meaningful procedure for requesting items that did not appear on the state's pre-approved list; Blue v. Bonta, 99 Cal.App.4th 980 (Cal.App.1.Dist., 2002) in which the court ruled that Medi-Cal cannot have a regulation that specifically excludes coverage of a stairway chair lift because Congress has mandated coverage for durable medical equipment and Medi-Cal may not categorically exclude coverage for items that are medically necessary.

C.

MSM 1303.10(d)(3)

A logical inconsistency exits in the Medicaid Services Manual insofar as it excludes rehabilitation from the definition of medical necessity yet contains a number of passages and regulations which authorize rehabilitative services and equipment. For example, MSM 100.4(15)(r) states that Nevada Medicaid receives federal funding to offer rehabilitation as an optional service; MSM 2400.1 provides comprehensive outpatient rehabilitation services. I propose to amend MSM 1303.10(d)(3) to exclude the phrase: "or rehabilitation" Thus, the sentence will read: "Equipment which the program determines is principally for education will not be approved. For example, electronic communication devices are not covered."

Legal Rationale:
Title 42, Chapter 7, Subchapter XIX, § 1396(2) specifically earmarks rehabilitation as a service States should render:

> For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

D.
"Respiratory Equipment Therapy" guidelines under the "DME Coverage and Limitations Guidelines."

The Respiratory Equipment Therapy" guidelines are unlawful and out of date: I propose to scrap the guidelines.

Legal & Medical Rationale:
The Respiratory Equipment Therapy" guidelines do not meet federal criteria insofar as they unlawfully discriminate on the basis of diagnosis, type of illness, or condition (42 C.F.R. § 440.230(c). This is because Medicaid provides airway clearance systems for patients with cystic fibrosis, only. Other problems exist: The criteria for receipt of an airway clearance system, particularly 11 and 12, are ineffective determinations of medical necessity; the guidelines cite to an airway clearance no longer on the market while ignoring existent airway clearance systems. See enclosure.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

September 4, 1998

Dear State Medicaid Director:

We have received a number of inquiries regarding coverage of medical equipment (ME) under the Medicaid program in light of the ruling of the United States Court of Appeals for the Second Circuit in DeSario v. Thomas. In that case, the court examined the circumstances under which a State may use a list to determine coverage of ME and offered its interpretation of HCFA's policies. We have concluded that it would be helpful to provide States with interpretive guidance clarifying our policies concerning ME coverage under the Medicaid program and the use of lists in making such coverage determinations. This guidance is applicable only to ME coverage policy.

As you know, the mandatory home health services benefit under the Medicaid program includes coverage of medical supplies, equipment, and appliances suitable for use in the home (42 C.F.R. § 440.70(b)(3)). A State may establish reasonable standards, consistent with the objectives of the Medicaid statute, for determining the extent of such coverage (42 U.S.C. § 1396(a)(17)) based on such criteria as medical necessity or utilization control (42 C.F.R. § 440.230(d)). In doing so, a State must ensure that the amount, duration, and scope of coverage are reasonably sufficient to achieve the purpose of the service (42 C.F.R. § 440.230(b)). Furthermore, a State may not impose arbitrary limitations on mandatory services, such as home health services, based solely on diagnosis, type of illness, or condition (42 C.F.R. § 440.230(c)).

A State may develop a list of pre-approved items of ME as an administrative convenience because such a list eliminates the need to administer an extensive application process for each ME request submitted. An ME policy that provides no reasonable and meaningful procedure for requesting items that do not appear on a State's pre-approved list, is inconsistent with the federal law discussed above. In evaluating a request for an item of ME, a State may not use a "Medicaid population as a whole" test, which requires a beneficiary to demonstrate that, absent coverage of the item requested, the needs of "most" Medicaid recipients will not be met. This test, in the ME context, establishes a standard that virtually no individual item of ME can meet. Requiring a beneficiary to meet this test as a criterion for determining whether an item is covered, therefore, fails to provide a meaningful opportunity for seeking modifications of or exceptions to a State's pre-approved list. Finally, the process for seeking modifications or exceptions must be made available to all beneficiaries and may not be limited to sub-classes of the population (e.g., beneficiaries under the age of 21).

In light of this interpretation of the applicable statute and regulations, a State will be in compliance with federal Medicaid requirements only if, with respect to an individual applicant's request for an item of ME, the following conditions are met:

- The process is timely and employs reasonable and specific criteria by which an individual item of ME will be judged for coverage under the State's home health services benefit. These criteria must be sufficiently specific to permit a determination of whether an item of ME that does not appear on a State's pre-approved list has been arbitrarily excluded from coverage based solely on a diagnosis, type of illness, or condition.
- The State's process and criteria, as well as the State's list of pre-approved items, are made available to beneficiaries and the public.
- Beneficiaries are informed of their right, under 42 C.F.R. Part 431 Subpart E, to a fair hearing to determine whether an adverse decision is contrary to the law cited above.

We encourage you to be cognizant of the approval decisions you make regarding items of ME that do not appear on a pre-approved list, to ensure that the item of ME is covered for all beneficiaries who are similarly situated. In addition, your list of pre-approved items of ME should be viewed as an evolving document that should be updated periodically to reflect available technology.

HCFA's Regional Offices will be monitoring compliance with the statute and regulations that are the subject of this guidance. Any questions concerning this letter or the ME benefit may be referred to Mary Jean Duckett of my staff at (410) 786-3294.

Sincerely,

/s/

Sally K. Richardson

Director

cc:

All HCFA Regional Administrators
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EQUIPMENT	QUALIFICATIONS	FORMS REQUIRED	COMMENTS
RESPIRATORY EQUIPMENT-OXYGENT			
Concentrators Portables Regulators 02 Carts Disposable O2 Supplies Tubing Cannulas O2 Masks Humidifiers	Arterial blood gases or an ear oximetry reporting: 1. PO2 Level of 60 mmHG or less on room air, OR 2. 80 mmHG or less on O2, OR 3. O2 Sat level of 89% or less, AND 4. Medical Necessity 5. Must list conditions of study (rest, sleeping, exercising, room air, on oxygen) CHILDREN: 92% or less room air sat, at rest *Liquid oxygen and related equipment are non-covered Medicaid services unless recipient does not have electrical utilities at residence. Reimbursement will be only for stationary at the same rate of concentrator.*	➢ Oximetry spot check or overnight tape results ➢ Medical documentation supporting qualifying factors. ➢ Prescription and/or MD signed PA/CMN Form	Oximetry test must be performed by a physician or qualified laboratory. O2 sats will not be accepted from an oxygen supplier. O2 sats must be performed within 60 days of requested dates of service.
RESPIRATORY EQUIPMENT THERAPY			
ABI Vest Airway Clearance System for Cystic Fibrosis	Qualifications: Indications for this form of therapy are described by the American Association for Respiratory Care (AARC) in the Clinical Practice Guidelines for Postural Drainage Therapy. The patient must have all of the following indicators: 1. Diagnosis of CYSTIC FIBROSIS, 2. Evidence of difficulty with secretion clearance: • Difficulty clearing secretions with expectorated sputum production greater than 30 ml/day for adults. • Evidence of retained secretions in the presence of an artificial airway, 3. Presence of atelectasis caused by mucus plugging, 4. Episodic or continuous bronchitis with symptoms of a productive cough, 5. Prescription for every day or more frequent airway clearance, 6. Age greater than 2 years, 7. Primary caregiver unable to provide consistent and effective therapy due to: ▪ Physical disability of the caregiver including, but not limited to, musculoskeletal syndromes, arthritis, and other chronic illness. • Time limitations of the caregiver to include but not limited to, single parenthood, parental employment, education, or multiple children in a household. • Severe disease requiring complex or frequent therapy. • Patient without capable partners, 8. Rehabilitation strategies requiring passive, self-administered, easily supervised therapy including: • Promotion of independence (self-care, self-reliance, and time economy) in the child to allow work, school, play, or athletics and/or • To allow independent living, 9. Failure of other airway clearance therapies including chest physical therapy and flutter, 10. Patient/family acceptance of Airway of the Airway Clearance Vest, 11. Patient has been hospitalized twice in the past 6 to 12 months, and 12. FEVI scores less than 80% of predicted value and FVC scores less than 50% of predicted value.	➢ Documentation Requirements: ➢ Documentation to include a patient specific assessment of the potential benefits versus potential risks utilizing AARC guidelines and specific indications for external manipulation of the thorax including evidence of retained secretions, evidence the patient is having difficulty with secretion clearance, or presence of atelectaisis caused by mucus plugging. It must be documented that the Vest therapy will prevent costlier treatment. ➢ Diagnosis for treatment ➢ Current medications, route of administration, dosage and frequency. ➢ Most recent Pulmonary Function Test score. ➢ Number of times per day patient needs chest physical therapy. ➢ Age ➢ Number of times the patient has been hospitalized in the past 6 months for this diagnosis. ➢ Identify primary caregiver and the caregiver availability. ➢ Is the prescribing physician willing to submit periodic follow-up reports? ➢ Prescription and/or MD signed PA/CMN Form	Reasons for Non-Coverage/Denial, include but are not limited to: 1. Patents who fail to meet the indicators. 2. Patients receiving duplication of services. Nevada Medicaid will not reimburse providers for bronchial drainage performed by a therapist or other health care professional while the patient has the bronchial drainage vest (i.e., home health services where physical therapist, nurse, and/or aide is performing chest PT and postural drainage). 3. Patients who possess a contraindication for external manipulation of the thorax as defined by AARC: - Head and/or neck injury which has not yet been stabilized. - Active hemorrhage without hemoddynamic instability - Subcutaneous emphysema -Recent epidural spinal infusion or spinal anesthesia or baclofen pump. -Recent skin grafts, or

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Appendix A

Non-covered Items

Air conditioners (includes swamp coolers)
Beds- Oscillating and lounge beds, bed baths and lifters, bedboards
Blood glucose analyzer- reflectance colorimeter
Car Seats
Control units and battery device adapters
Cervical roll or pillow
Dehumidifiers- room or central
Diathermy machines
Disposable wipes (Includes baby and Attends wash cloths)
Elevators and stair lifts
Enuresis or bed-wetting alarms
Environmental products (e.g., air filters, purifiers, conditions, hypoallogenic bedding, and linens)
Exercise equipment
Food blenders
Heat and massage foam cushion pads
Home security systems
Household equipment and supplies such as ramps, switches, tableware, and feeding instruments (Home modification equipment)
Humidifiers –room type or central
Hygiene supplies and equipment, including hand-held shower units and shower trays, and dental care supplies and equipment
Ice packs (disposable)
Instructional materials (e.g., pamphlets and books)
Isolation gowns, surgical gowns and masks
Lift chairs
Magnifying glasses
Massage devices
Medical alert bracelets and response systems
Medical supplies defined as drugs
Menses products (e.g., sanitary pads)
Motorized lifts for a vehicle
Orthopedic mattresses
Overbed Tables
Oximetry Testing
Personal computers and printers, tape recorders, or video recorders
Pulse tachometers
Ramps (ex: Wheelchair ramps)
Reachers
Reading glasses
Rehabilitation equipment (e.g., traction devices)
Safety/Canopy Beds
Scales (e.g. bathroom, diet)

Strollers
Table foods
Telephones, telephone alert systems, telephone arms, or answering machines
Tennis/gym shoes
TENS Units and supplies
Thermometer covers
Toothbrushes and toothettes
Toys
Waterbeds
Items used for Recreation activities (e.g. swim plugs)

*Please note: This list is not all-inclusive

DEPARTMENT OF HEALTH AND FAMILY SERVICES

Profile of Chronic Conditions in Medicaid Managed Care

Reporting Period:
Calendar Year 2004

The Department of Health and Family Services works closely with participating health maintenance organizations (HMOs) to assure that necessary services are provided to enrollees. Monitoring the level of services delivered by each HMO provides the Division of Health Care Financing with an estimate of enrollee access to needed services, and provides the HMOs with information that permits targeting of resources to reach populations that may not have optimal service utilization. This health profile is one component of the overall monitoring system.

Certain adverse outcomes associated with chronic conditions can be prevented with appropriate medical care and patient compliance. For this reason, this Profile of Chronic Conditions highlights the ambulatory management of diabetes and the management of asthma in Medicaid managed care.

To generate the data in this health profile, Medicaid Encounter Data Driven Improvement Core Measure Set (MEDDIC-MS)[1] performance measures were applied to HMO-submitted encounter data and other Division sources such as Medicaid eligibility data and fee-for-service claims data. In the charts that follow, the 13 participating Medicaid HMOs are represented by a three letter abbreviation. A key containing the HMO abbreviations and names is located on page 2.

Ambulatory Management of Diabetes

Many adverse outcomes related to diabetes (such as retinopathy, neuropathy and nephropathy) can be prevented, or at least delayed by an aggressive program of preventive care, prompt identification of problems, early intervention and treatment.[2] As part of their overall framework for the prevention of diabetic complications, the Wisconsin Diabetes Advisory Group recommends an HbA1c test every 3 to 6 months and a lipid profile yearly.[3]

Chart 1 compares the HMO's percentage of 18-75 year-old enrollees with diabetes who received at least one HbA1c test during calendar year (CY) 2003 and CY 2004.[4] Four HMOs (AHP, MCH, UHC and UHP) show statistically significant increases in rates with no HMOs showing a statistically significant decrease. The mean percentage for all HMOs in CY 2004 is 82.3%, a statistically significant increase from 78.3% in CY 2003.

Chart 2 compares the HMO's percentage of 18-75 year-old enrollees with diabetes who received at least one lipid profile during CY 2003 and CY 2004.[4] Seven HMOs (AHP, GHE, HTM, NHP, SHP, MHS, UHC and UHP) show statistically significant increases in rates. The mean percentage for all HMOs in CY 2004 is 67.1%, a statistically significant increase from 61.9% in CY 2003.

Chart 1: Percent of Enrollees with Diabetes with HbA1c Test (CY 2003 and CY 2004)

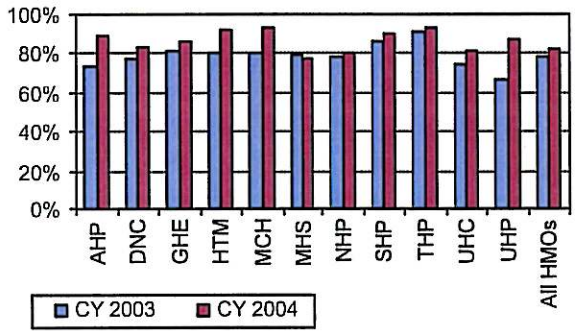
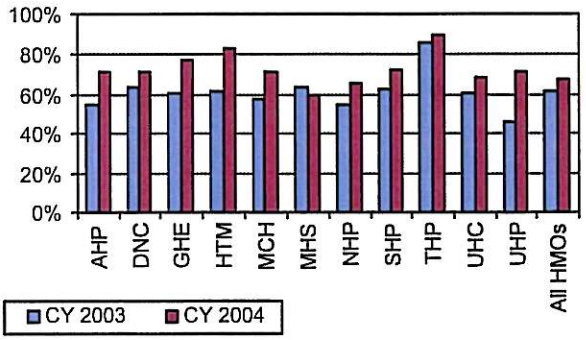


Chart 2: Percent of Enrollees with Diabetes with Lipid Profile (CY 2003 and CY 2004)



DEPARTMENT OF HEALTH AND FAMILY SERVICES

One West Wilson Street
Madison, WI 53703

Published February 2006

[1] The MEDDIC-MS measure specifications are available from the Bureau of Managed Health Care Programs in the Division of Health Care Financing.
[2, 3] Essential Diabetes Mellitus Care Guidelines. The Wisconsin Diabetes Advisory Group. 2004.

Asthma

Chart 3: Percent of Enrollees with Asthma with Emergency Department Visit (CY 2004)

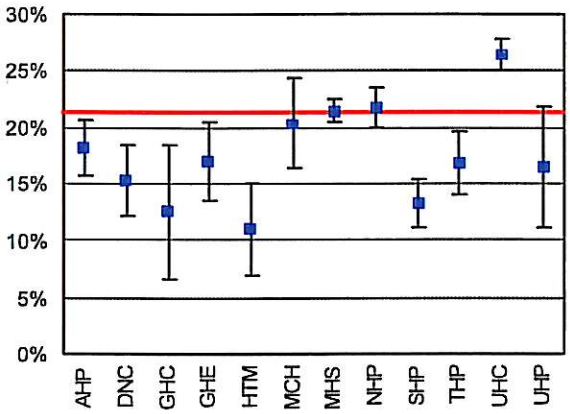


Chart 4: Percent of Enrollees with Asthma with Emergency Department Visit (CY 2003 and 2004)

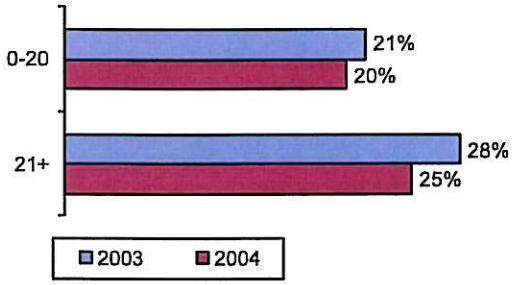
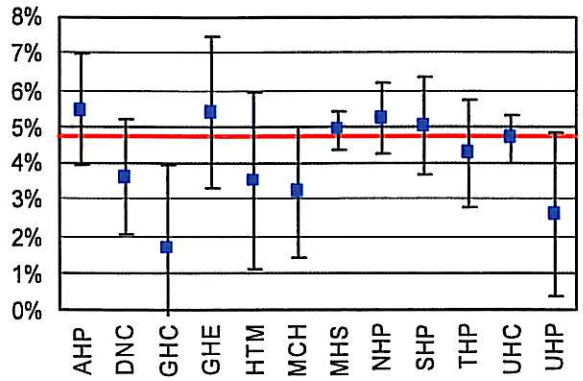


Chart 5: Percent of Enrollees with Asthma with Inpatient Hospital Stay (CY 2004)



Asthma is a chronic respiratory illness that affects many children and adults in the Medicaid program. In CY 2004, 6.2% of children (0-20 years) and 4.9% of adults (21+ years) in Medicaid HMOs had asthma. The prevalence rate for both children and adults did not differ significantly from 2003 to 2004. It is important to effectively manage the care of those persons that do have asthma to decrease adverse outcomes.

Use of the emergency room or inpatient hospital for asthma care may indicate inadequate access to primary care, sub-optimal care or poor patient compliance. Charts 3 and 4 display the rates of emergency department utilization, while chart 5 displays the rate of inpatient hospital utilization of enrollees with asthma.[5]

Chart 3 shows the percent of enrollees with asthma (all ages) that had one or more emergency department visits in CY 2004, by HMO. The mean percentage for all HMOs is 21.2%, a statistically significant decrease from the CY 2003 rate of 23.2%. Many HMOs (AHP, DNC, GHC, GHE, HTM, SHP, and THP) have rates statistically below the all-HMO rate. One HMO (UHC) has a rate that is statistically higher than the all-HMO rate.

Chart 4 shows that emergency department visit rates for both children (0-20 years) and adults (21+ years) decreased from 2003 to 2004. These differences are statistically significant. In both years, a greater percentage of adults with asthma visited the emergency room than children.

Chart 5 shows the percent of enrollees with asthma (all ages) that had one or more inpatient hospital stays due to asthma in CY 2004, by HMO. The mean percentage for all HMOs is 4.8%. One HMO (GHC) has a rate statistically below the overall mean; all other HMOs have rates that are statistically indistinguishable from the all-HMO mean.

In CY 2004 as in CY 2003, the adult inpatient hospital stay rate (5.1%) was higher than the child rate (4.6%).

HMO Abbreviations and Names

AHP–Atrium Health Plan
DNC–Dean Health Plan
GHC–Group Health South Central
GHE–Group Health Eau Claire
HTM–Health Tradition Health Plan
MCH–MercyCare Insurance
MHS–Managed Health Services
NHP–Network Health Plan
SHP–Security Health Plan
THP–Touchpoint Health Plan
UHC–UnitedHealthcare
UHP–Unity Health Insurance
VHP–Valley Health Plan

[5] Results from HMOs with less than 30 enrollees meeting the MEDDIC-MS denominator criteria are not displayed in the charts.